ConnectiCare

FlexPOS $40/$80 $2,750 20% Fixed Funding Solutions Open Access Contract Year Benefit Summary

Your ConnectiCare health plan helps you get the care you need. Here are the most frequently used services. Refer to your employer's Health Plan Description for a complete list of benefits. All benefits described below are per member per plan year.

In-Network Preventive Services
These services are no cost to you when you use an **in-network** doctor or facility. Frequency is based on age and gender. For a complete list of preventive services and to find a doctor, refer to connecticare.com.

Getting care within ConnectiCare's network typically costs you less. You may also get care outside of our network; however, your share of the costs will be higher. Out-of-network doctors and facilities do not appear in the "Find a doctor" directory on connecticare.com.

- **Physical**
- **Well woman visit and pap test**
- **More than 25 screenings, including mammograms and colonoscopies**
- **Flu shot**
- **Vaccinations**
- **Certain birth control and other prevention medications**

	In-network member pays	**Out-of-network member pays**
Your deductible	$2,750 Individual $5,500 Family	$7,000 Individual $14,000 Family
Your out-of-pocket maximum Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services	$6,000 Individual $12,000 Family	$15,800 Individual $31,600 Family
Out-of-network reimbursement	Not applicable	Plan will reimburse the coinsurance percentage of the maximum allowable amount
After you have spent the out-of-pocket maximum amount, ConnectiCare will pay 100% of your covered health care expenses for the remainder of the year.		
Screenings	**In-network member pays**	**Out-of-network member pays**
Baseline routine mammography (ages 35-39)	$50 copayment/service; deductible does not apply at a Stand-alone Facility 20% coinsurance after plan deductible at a Hospital Facility	50% coinsurance after plan deductible
Annual routine mammography (age 40 or older)	No charge	50% coinsurance after plan deductible

Screenings	In-network member pays	Out-of-network member pays
Breast ultrasound	$50 copayment/service; deductible does not apply at a Stand-alone Facility 20% coinsurance after plan deductible at a Hospital Facility	50% coinsurance after plan deductible
Annual routine vision exam	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Allergy testing up to one visit per year	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
Ongoing Care and Sick Visits	**In-network member pays**	**Out-of-network member pays**
Primary care services (includes office and telemedicine services)	$40 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Specialist services (includes office and telemedicine services)	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Gynecologist services	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Maternity and prenatal care visits May not apply to all laboratory and radiology services – refer to your plan documents	No charge	50% coinsurance after plan deductible
Allergy injections up to 20 visits every year	Refer to your applicable primary care or specialist cost share	50% coinsurance after plan deductible
Telemedicine visit (services rendered by a Teladoc® provider) Primary Care – members must be 18 or older	**Primary Care, Mental Health and General Medical Services:** No Charge **Dermatologist:** $80 copayment/ visit; deductible does not apply	50% coinsurance after plan deductible
Retail clinic	$40 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Lab and Radiology Performed in a hospital, lab or radiology facility	**In-network member pays**	**Out-of-network member pays**
Laboratory services	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Non-advanced radiology X-ray, diagnostic	$50 copayment/service; deductible does not apply at a Stand-alone Facility 20% coinsurance after plan deductible at a Hospital Facility	50% coinsurance after plan deductible

Lab and Radiology **Performed in a hospital, lab or radiology facility**	**In-network member pays**	**Out-of-network member pays**
Advanced radiology **Hospital facility** MRI, PET and CAT scan and nuclear cardiology	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Advanced radiology **Stand-alone facility** MRI, PET and CAT scan and nuclear cardiology up to five copayments per year, then copayment waived	$100 copayment/service; deductible does not apply	50% coinsurance after plan deductible
Sudden and Unexpected Care	**In-network member pays**	**Out-of-network member pays**
Urgent care or other walk-in clinic	$75 copayment/visit; deductible does not apply	Same as In-network benefit
Emergency room copayment waived if admitted	$350 copayment/visit; deductible does not apply	Same as In-network benefit
Ambulance	$350 copayment per trip; deductible does not apply	Same as In-network benefit
Inpatient Hospital Services	**In-network member pays**	**Out-of-network member pays**
Inpatient hospital services, including room and board	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Skilled nursing and rehabilitation facilities up to 90 days per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient Hospital Services and Home Care	**In-network member pays**	**Out-of-network member pays**
Hospital outpatient facilities	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Ambulatory surgical center	$400 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Home health services up to 100 visits per year	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient Rehabilitative Services	**In-network member pays**	**Out-of-network member pays**
Rehabilitative Services up to 40 visits per contract year includes services combined for physical, speech and occupational therapy	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Chiropractic services up to 20 visits per year	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible

Mental Health and Substance Abuse	In-network member pays	Out-of-network member pays
Inpatient mental health services	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Inpatient alcohol and substance abuse treatment	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment office visits and home services	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Outpatient mental health, alcohol and substance abuse treatment intensive outpatient treatment and partial hospitalization	$80 copayment/visit; deductible does not apply	50% coinsurance after plan deductible
Supplies	**In-network member pays**	**Out-of-network member pays**
Durable medical equipment including prosthetics and disposable medical supplies	20% coinsurance after plan deductible	50% coinsurance after plan deductible
Diabetic equipment and supplies	20% coinsurance after plan deductible	50% coinsurance after plan deductible

Important information

- This is a brief summary of benefits. Refer to your employer's Health Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described are per member per plan year.
- If you have questions regarding your plan, visit our website at **www.connecticare.com** or call us at (860) 674-5757 or 1-800-251-7722.
- To learn more about your Teladoc® benefits contact Teladoc® at teladoc.com/connecticare or call 1-800-835-2362 (TTY:711).
- Out-of-network reimbursement is based on the maximum allowable amount. Members are responsible to pay any charges in excess of this amount. Please refer to your employer's Health Plan Description for more information.
- If you are a Massachusetts resident, this plan along with pharmacy services meets Massachusetts Minimum Creditable Coverage standards for 2023.
- Your plan is administered by ConnectiCare Insurance Company, Inc.

ConnectiCare

Prescription Drug Copayment Plan Benefit Summary

This is a brief summary of your prescription drug benefits. Refer to your employer's Health Plan Description for complete details on benefits, conditions, limitations and exclusions, or consult with your benefits manager. All benefits described below are per member per plan year.

Covered prescription drugs through retail participating pharmacies or our mail order service. Generics are dispensed unless the member pays the Generic drug cost-share plus the difference in price between the generic equivalent and the brand name drug. Your Plan includes the following: Mandatory drug substitution, Generic substitution program, Tiered cost-share program, and Voluntary mail order program.

	In-network member pays	**Out-of-network member pays**
Your deductible	None	None
Your out-of-pocket maximum (Includes a combination of deductible, copayments and coinsurance for medical and pharmacy services)	$6,000 Individual $12,000 Family	$15,800 Individual $31,600 Family
Retail Pharmacy (up to a 30 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs Tier 1	$10 copayment/prescription	50% coinsurance
Non-preferred Generic Tier 2	50% coinsurance up to $250 maximum per prescription	50% coinsurance
Preferred Brand Tier 3	$50 copayment/prescription	50% coinsurance
Non-Preferred Brand Tier 4	50% coinsurance up to a maximum of $500 per prescription	50% coinsurance
Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Generic drugs Tier 1	$20 copayment/prescription	Not covered
Non-preferred Generic Tier 2	50% coinsurance up to $500 maximum per prescription	Not covered

Mail Order Pharmacy (up to a 90 day supply per prescription)	**In-network member pays**	**Out-of-network member pays**
Preferred Brand Tier 3	$100 copayment/prescription	Not covered
Non-Preferred Brand Tier 4	50% coinsurance up to $1,000 maximum per prescription	Not covered
Specialty drugs (up to a 30 day supply per prescription) These drugs generally require pre-authorization and may require special handling	**In-network member pays**	**Out-of-network member pays**
Preferred Specialty drugs Tier 5	50% coinsurance up to $500 maximum per prescription	Not covered
Non-preferred Specialty drugs Tier 6	50% coinsurance up to $750 maximum per prescription	Not covered

Additional information

- Under this program covered prescription drugs and supplies are put into categories (i.e., tiers) to designate how they are to be covered and the member's cost-share. The placement of a drug or supply into one of the tiers is determined by the ConnectiCare Pharmacy Services Department and approved by the ConnectiCare Pharmacy & Therapeutics Committee based on the drug's or supply's clinical effectiveness and cost, not on whether it is a generic drug or supply or brand name drug or supply.
- Most specialty drugs are dispensed through specialty pharmacies by mail, up to a 30 day supply. Specialty pharmacies have the same member cost share as all other participating pharmacies and are not part of ConnectiCare's Mandatory mail order program. The member cost share for specialty pharmacy is different from the cost share for ConnectiCare's mail order program.
- 90 day supply of maintenance medications must be filled through Express Scripts home delivery or a participating Walgreens pharmacy.